MARIANNE MORELLI, D.M.D.
BROOKFIELD FAMILY DENTISTRY, LLC

INFORMED CONSENT FOR SINUS ELEVATION/AUGMENTATION SURGERY

You have the right to be given pertinent information about your proposed sinus lift surgery so that you have sufficient information to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is a confirmation that we have discussed the nature of the proposed treatment, the known risks associated with it and the feasible alternate treatments.

Please initial each paragraph after reading. If you have any questions, please ask Dr. Morelli BEFORE initialing.

_____ 1. I, _____, hereby authorize Marianne Morelli, D.M.D. and any other agents, assistants or employees selected by Dr. Morelli to treat the condition described as:_____
_____

_____ 2. The procedure necessary to treat the condition has been explained to me. I understand the nature of the procedure to be:_____
_____

_____ 3. I understand incisions will be made inside my mouth in the back part of my upper jaw that will allow for a bony window to be outlined and then very carefully repositioned with elevation of the sinus membrane to allow for graft material to be placed. This procedure is being done to allow for ultimate placement of root form implants that will allow crowns or dentures to be placed ultimately. I acknowledge that the doctor has explained the procedure, including the location of the incisions and types of implants ultimately to be used. I understand that the crown, bridge, denture that will later be attached to these implants will be made and attached by Marianne Morelli, D.M.D. and that a separate charge will be made for that work

_____ 4. I understand that the graft material must be in place for at least ____ months before it can be exposed for placement of implant(s). I understand that a subsequent surgery will be required to uncover the top of the implants that will be placed in this graft

_____ 5. No guarantee can be or has been given that the graft will consolidate and thus be adequate for implant placement. It has also been explained to me that once implants are inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implants and even grafts may fail.

_____ 6. I have been informed of possible alternative methods of treatment (if any), and they include_____
_____
_____ I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

_____ 7. It has been explained to me that during the course of this procedure, unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure from those set forth in paragraph 2 above. In rare cases, it may not be possible to continue with the procedure. I authorize Dr. Morelli and her staff to perform such different procedure(s) as necessary and desirable in the exercise of professional judgement.

DIPLOMATE,
AMERICAN BOARD OF PERIODONTOLOGY
AND IMPLANT DENTISTRY

834 FEDERAL ROAD, BROOKFIELD, CT 06804
EMAIL: OFFICE@DRMORELLI.COM
OFFICE: (203)775-6167
FAX: (203)775-6169

_____ 8. Dr. Morelli has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance, such risk include, but are not limited to, the following:

_____ A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
_____ B. Prolonged or heavy bleeding that may require additional treatment
_____ C. Injury or damage to adjacent teeth or roots of adjacent teeth if present.
_____ D. Postoperative infection that may require additional treatment including removal of the graft.
_____ E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
_____ F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ). Pre-existing TMJ symptoms may be worsened.
_____ G. Injury to the nerve branches of the upper jaw resulting in numbness or tingling of the lower eyelid, side of the nose and upper lip/cheek area along with the gums on the operated side. This may persist for several weeks, months, or, in rare instances permanently.
_____ H. Some bleeding through the nostrils on the side of the surgery may occur which usually will last one to two days
_____ I. I understand if I am a smoker, use chewing tobacco, vape or use any form of marijuana this can decrease the success of the procedure. I should not smoke or perform the previously listed habits one day prior to surgery, the day of surgery and one day following surgery as this may case a decrease change in the success of the procedure.
_____ J. Swelling around the eye on the surgery side may even result in closing of the eye for a day or two
_____ K. Opening into the sinus after surgery can occur and would require additional treatment.
_____ L. Infection of the graft, possibly necessitating its total removal. The removal of grafted bone from any donor site has its own potential risks and complications, which also have been explained to me.
_____ M. Other:_____

_____ 9. I consent to the administration of local anesthesia in connection with the procedure referred to above.

_____ 10. I have been made aware that certain medications, drugs, anesthetics and prescriptions which I may be given can cause drowsiness, incoordination, and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or machinery and not to return to work while taking such medications, or until fully recovered from the effects of the same. If I am to be given a general sedative mediation during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedative medication.

_____ 11. It has been explained to me, and I understand, that a perfect result is not and cannot be guaranteed or warranted.

_____ 12. I certify that I speak, read and write English and have read and fully understand this consent for surgery; and that all blanks were filled in prior to my initialing and signing this form.

_____ 13. I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

Please ask Dr. Morelli if you have any questions concerning this consent form.

_____
Patient Name (printed)

_____ _____
Patient or legal guardian signature Date

_____ _____
Doctor's signature Date

Diplomate,
American Board of Periodontology
and Implant Dentistry

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Office: (203)775-6167
Fax: (203)775-6169